

Dental Medical Loss Ratio GUIDANCE

REPORTING OF MEDICAL LOSS RATIO (MLR) BY HEALTH PLANS OR HEALTH INSURERS (version052019)

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§1 Basis and scope.

- (a) Basis. This guidance implements Health and Safety Code section 1367.004 and Insurance Code section 10112.26.
- (b) Scope. Sections 4 through 12 of this guidance establish the requirements for a health care service plan or health insurer that issues, sells, renews, or offers a specialized health care service plan contract or specialized health insurance policies to groups or individuals for dental health coverage to report information concerning premium revenues and the use of such premium revenues for dental services provided to enrollees, activities that improve dental health care quality, and all other non-claims costs. Sections 13 through 16 describe how this information will be used to calculate the MLR for each reporting year.

§2 Applicability.

The requirements described in this guidance apply to a health care service plan or health insurer that issues, sells, renews, or offers specialized dental health care service plan

contracts or specialized health insurance policies to groups or individuals for dental health coverage. The term “dental coverage” means benefits consisting of dental care under a dental service plan contract or specialized health insurance policy. This definition applies to any stand-alone dental products.

This guidance does not apply to a health care service plan contract issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

§3 Definitions.

For the purposes of this guidance, the following definitions apply unless otherwise specified.

Enrollee means a person who is enrolled in a health plan or with a health insurer and who is a recipient of services from the health plan or health insurer.

Experience rating refund means the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention, and margin are less than earned premium.

Dental plan contract means dental service coverage offered through either individual coverage or a group dental contract or a specialized health insurance policy.

Individual market means the market for dental health insurance coverage offered to individuals other than in connection with a group health plan. A sole proprietor or a sole proprietor’s spouse is an individual and not a group of one.

MLR reporting year means a calendar year during which group or individual dental coverage is provided by a specialized health care service plan or specialized health insurance policy covering dental services.

Policyholder means any entity that has entered into a contract with a health care service plan or health insurer to receive dental services coverage.

Small employer means an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the MLR reporting year.

Large employer means an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the MLR reporting year.

Subscriber refers to both the group market and the individual market. In the group market, subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan or policy and whose employer is generally responsible for the payment of premiums. In the individual market, subscriber means the individual who purchases an individual health plan or policy and who is generally responsible for the payment of premiums.

Unearned premium means the portion of the premium paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year.

Unpaid claim reserves means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but were not paid within 3 months of the end of the MLR reporting year.

Disclosure and Reporting

§4 Reporting requirements related to premiums and expenditures.

- (a) *General requirements.* For each MLR reporting year, a health plan must submit to the Department of Managed Health Care (DMHC), and a health insurer must submit to the California Department of Insurance (CDI), a report which complies with the requirements of Health and Safety Code section 1367.004 and Insurance Code section 10112.26, concerning premium revenue and expenses related to all group and individual dental service coverage.
- (b) *Timing and form of report.* The report must be submitted to the DMHC and CDI no later than July 31 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the DMHC and CDI.
- (c) *Transfer of business.* Health plans that purchase a line or block of business from another health plan during an MLR reporting year are responsible for submitting the required information and reports for the assumed business, including for that part of the MLR reporting year that preceded the purchase.

§5 Aggregate reporting.

- (a) *General requirements.* For purposes of submitting the report required by Health and Safety Code section 1367.004 and Insurance Code section 10112.26, the health plan or health insurer must submit a report that includes the experience of all specialized dental health plans or policies during the MLR reporting year covered by the report. The report must aggregate data for each entity licensed within California, aggregated separately for the large group market, the small group market, and the individual market. Experience with respect to each policy must be included on the report submitted with respect to all health plans or policies issued in California, including those specified in paragraph (b) of this section.

(b) *Specific requirements.*

- (1) For an individual market product sold through an association or trust which provides dental service coverage to California enrollees, the experience of the health plan or health insurer must be included in the MLR Form.
- (2) For an employer-sponsored product issued through a group trust or multiple employer welfare association which provides dental service coverage to California enrollees, the experience of the health plan or health insurer must be included in the MLR Form.

§6 Newer experience.

If, for any aggregation as described in §5, 50 percent or more of the total earned premium for an MLR reporting year is attributable to policies newly issued in that MLR reporting year, then the experience of these policies may be excluded from the report for that same MLR reporting year. If an issuer chooses to defer reporting of newer business as provided in this section, then the excluded experience must be added to the experience reported in the following MLR reporting year.

§7 Premium revenue.

- (a) *General requirements.* A health plan or health insurer must report to the DMHC and CDI the earned premium for each MLR reporting year. Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving dental service coverage from the health plan or health insurer, including any fees or other contributions associated with the health plan or health insurer.
- (1) Earned premium is to be reported on a direct basis except as provided in paragraph (b) of this section.
 - (2) All earned premium for policies issued by one health plan or health insurer and later assumed by another health plan or health insurer must be reported by the assuming health plan or health insurer for the entire MLR reporting year during which the policies were assumed and no earned premium for that MLR reporting year must be reported by the ceding health plan or health insurer.
- (b) *Adjustments.* Earned premium must include adjustments to account for any experience rating refunds incurred and account for unearned premium.

§8 Reimbursement for dental clinical services provided to enrollees.

- (a) *General requirements.* The report must include direct claims paid to or received by providers, including under capitation contracts with dental providers, whose services are covered by the contract for dental clinical services or supplies covered by the contract. In addition, the report must include claim reserves associated with claims

incurred during the MLR reporting year, reserves for contingent benefits and the dental claim portion of lawsuits, and any incurred experience rating refunds. Reimbursement for dental clinical services is referred to as “incurred claims” herein. All components of and adjustments to incurred claims must be calculated based on claims incurred only during the MLR reporting year and paid through March 31st of the following year.

- (1) Incurred claims must include the current year’s unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits, and claim recoveries received as a result of subrogation.
- (2) Incurred claims must include claims incurred but not reported based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.
- (3) Incurred claims must include changes in other claims-related reserves.
- (4) Incurred claims must include incurred experience rating refunds.

(b) *Adjustments to incurred claims.*

- (1) Adjustments that **must be deducted** from incurred claims.
 - (i) Overpayment recoveries received from providers.
- (2) Adjustments that **must be included** in incurred claims.
 - (i) The amount of incentive and bonus payments made to providers.
- (3) Adjustments that **must not be included** in incurred claims.
 - (i) Amounts paid to third party vendors for secondary network savings.
 - (ii) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
 - (iii) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, dental record copying costs, attorneys’ fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to dental personnel, and dental record clerks must not be included in incurred claims.

§9 Other non-claims costs.

(a) *General requirements.* The report must include non-claims costs described in paragraph (b) of this section and must provide an explanation of how premium revenue is used, other than to provide reimbursement for dental clinical services covered by the health plan, Federal and State taxes, and Federal and State licensing or regulatory fees as specified in this guidance.

(b) *Non-claims costs other than taxes and regulatory fees.*

- (1) The report must include any expenses for administrative services that do not constitute adjustments to premium revenue as provided in §7 of this guidance, and to reimbursement for dental clinical services to enrollees as defined in §8 of this guidance.
- (2) Expenses for administrative services include the following:
 - (i) Quality improvement expenses considered as administrative expenses for MLR calculation purposes.
 - (ii) Cost containment expenses considered as administrative expenses for MLR calculation purposes.
 - (iii) Loss adjustment expenses not classified as a cost containment expense.
 - (iv) Direct sales salaries, workforce salaries, and benefits.
 - (v) Agents and brokers fees and commissions.
 - (vi) General and administrative expenses.
 - (vii) Community benefits expenditures.

§10 Reporting of Federal and State licensing and regulatory fees.

(a) *Licensing and regulatory fees included.* The report must include statutory assessments to defray operating expenses of any State or Federal department, and examination fees specified by State law.

(b) *Licensing and regulatory fees excluded.* The fees excluded from §10 (a) such as fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments should be reported as other non-claims costs, but not as an adjustment to premium revenue.

§11 Reporting of Federal and State taxes.

(a) *Federal taxes.* The report must separately report the following:

- (1) Federal taxes excluded from premium under §13 through §16 which includes all Federal taxes and assessments allocated to dental service coverage reported under the Health and Safety Code and Insurance Code.
- (2) Federal taxes not excluded from premium under §13 through §16 which includes Federal income taxes on investment income and capital gains as other non-claims costs.

(b) *State taxes and assessments.* The report must separately report the following:

- (1) State taxes and assessments excluded from premium under §13 through §16 which includes:
 - (i) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.
 - (ii) Guaranty fund assessments.
 - (iii) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.
 - (iv) State income, excise, and business taxes other than premium taxes.
 - (v) State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes.
 - (vi) Payments made by a Federal income tax exempt health plan for community benefit expenditures as defined in paragraph (c) of this section, limited to the highest of either:
 - (A) Three percent of earned premium, or
 - (B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the health plan's earned premium in the applicable State market.
 - (vii) In lieu of reporting amounts described in paragraph (b)(1)(v) of this section, a health plan or health insurer that is not exempt from Federal income tax may choose to report payment for community benefit expenditures as described in paragraph (c) of this section, limited to the highest premium tax rate in the State for which the report is being submitted multiplied by the health plan or health insurer earned premium in the applicable State market.

- (2) State taxes and assessments not excluded from premium under §13 through §16 which includes:
 - (i) State sales taxes if the health plan or health issuer does not exercise options of including such taxes with the cost of goods and services purchased.
- (c) *Community benefit expenditures.* Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to oral health care services, enhancing public health, and relief of government burden. This includes any of the following activities that:
 - (1) Are available broadly to the public and serve low-income consumers;
 - (2) Reduce geographic, financial, or cultural barriers to accessing oral health care services, and if ceased to exist would result in access problems (for example, longer wait times, or increased travel distances);
 - (3) Address Federal, State, or local public health priorities such as advancing oral health care knowledge through education or research that benefits the public;
 - (4) Leverage or enhance public health department; or
 - (5) Otherwise would become the responsibility of government or another tax-exempt organization.

§12 Allocation of expenses.

- (a) *General requirements.* Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business or products other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.
- (b) *Description of the methods used to allocate expenses.* The report must include a detailed description of the methods used to allocate expenses, including incurred claims, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, to each health insurance market in California. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

- (1) Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, a health plan or health insurer should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.
 - (2) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.
 - (3) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios, or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.
- (c) *Disclosure of allocation methods.* A health plan or health insurer must identify in the report the specific basis used to allocate expenses reported by lines of business including the individual market, small group market, and large group market.
- (d) *Maintenance of records.* A health plan or health insurer must maintain and make available to the DMHC or CDI upon request the data used to allocate expenses reported under this section together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the report.

Calculating Medical Loss Ratio (MLR)

§13 Aggregation of data in calculating a health plan or health insurer's MLR.

- (a) *Aggregation by market.* In general, a health plan or health insurer's MLR must be calculated separately for the large group market, small group market, and individual market within California.
- (b) *Years of data to include in calculating MLR.* A health plan or health insurer's

MLR for an MLR reporting year is calculated according to the formula in §14 of this guidance and aggregating the data reported under this section for the following 3-year period.

- (1) The data for the MLR reporting year whose MLR is being calculated.
- (2) The data for the two prior MLR reporting years.

§14 Formula for calculating a health plan or health insurer's MLR.

(a) *Medical loss ratio.*

- (1) A health plan or health insurer's MLR is the ratio of the numerator, as defined in paragraph (b) of this section, to the denominator, as defined in paragraph (c) of this sections.
- (2) A health plan or health insurer's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

(b) *Numerator.* The numerator of a health plan or health insurer's MLR for a MLR reporting year must be the health plan or health insurer's incurred claims, as defined in §8 of this guidance that are reported for the years specified in §13 of this guidance.

(c) *Denominator.* The denominator of a health plan or health insurer's MLR must equal a health plan or health insurer's premium revenue, as defined in §7, excluding a health plan or health insurer's Federal and State taxes and licensing and regulatory fees, described in §10(a) and §11(a)(1) and (b)(1).

§15 Credible experience.

(a) *General rule.* A health plan or health insurer is not be subject to the MLR requirements if a health plan or health insurer's experience is non-credible, as defined in paragraph (c)(2) of this section.

(b) *Life-years.* The credibility of a health plan or health insurer's experience is based upon the number of life-years covered by the health plan or health insurer. Life-years means the total number of months of coverage for enrollees whose premiums and claims experience is included in the report, divided by 12.

(c) *Credible experience.*

- (1) A MLR calculated under §14 of this guidance is credible if it is based on the experience of 1,000 or more life-years.

- (2) A MLR calculated under §14 of this guidance is non-credible if it is based on the experience of less than 1,000 life-years.

§16 Life-years used to determine credible experience.

- (a) The life-years used to determine the credibility of a health plan or health insurer's experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years.